September 16, 2016

The Honorable Secretary Sylvia Burwell
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: New Hampshire Health Protection Program Section 1115 Demonstration

Dear Secretary Burwell:

We appreciate the opportunity to comment on New Hampshire's proposed Health Protection Program (HPP) § 1115 Demonstration. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

NHeLP is supportive of continued Medicaid expansion in New Hampshire. The current expansion has been extremely successful and provides coverage to almost 50,000 state residents. We encourage HHS and the State to develop a demonstration to continue this successful program. However, HHS should not approve a few components of the current demonstration proposal as these features are not authorized by Medicaid law and are harmful to enrollees. New Hampshire's proposal to alter the successful expansion should face a high "do no harm" standard for approval. We urge HHS to work with New Hampshire to preserve Medicaid expansion without harming current enrollees or jeopardizing enrollees in other states who may be affected by similar proposals. In its review, we urge HHS to zealously enforce its stated policies and the words of the Social Security Act's § 1115.

A. Waiver List

The most critical component of any § 1115 demonstration application is the waiver list – the list of provisions that are being waived to conduct the demonstration. The whole purpose of a demonstration is to waive those legal requirements. Without a precise statement of the provisions being waived it is impossible to evaluate whether the waivers are even legal, much less innovative. While the waiver list sometimes appears prominently in

the application itself, in other instances it is a stand-alone attachment (that may or may not in fact be attached to the publicly available materials), and yet in other situations – as in this case – it is nowhere to be found. The closest thing we have to a waiver list for New Hampshire is the waiver list that appears in the materials submitted as evidence of state-level public notice of filing. That list of course, reflects the waivers proposed to be requested at the time of the *state* comment process, and does not necessarily reflect the waivers requested at the time of federal application.

We respectfully request that HHS should not consider an application complete until and unless a complete waiver list is prominently included in the application itself (not as a separate attachment). If, as in this case, a waiver list is not included, HHS should require that the application be resubmitted with the waiver list included and at that point start a new 30 day comment period. All of our comments below are made without any certainty of the actual waivers requested and as such cannot be considered complete.

B. Work Requirements

HHS should not approve any waiver permitting New Hampshire to condition Medicaid eligibility on compliance with work search activities. Work search requirements are an illegal condition of eligibility in excess of the Medicaid eligibility criteria clearly enumerated in Federal law.[1] Medicaid is a medical assistance program, period. Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law,[2] and courts have held additional eligibility requirements to be illegal.[3] Section 1115 cannot be used to short circuit the Medicaid protections, because work search requirements do not promote the objectives of the Medicaid Act or demonstrate anything. From a practical stand point, work requirements applied to health coverage get it exactly backwards. An individual needs to be healthy to be able to work, and a work requirement can prevent an individual from getting the health care they need to be able to work. We note finally that in almost any system in which eligibility is conditioned or attached to work search, there are likely to be serious violations of nondiscrimination laws, as persons with certain health conditions or disabilities may be unable to maintain enrollment due to their condition or the lack of adequate systemic supports to foster their employment.

We urge HHS to make clear to the state that any state work search programs cannot be tied to Medicaid or otherwise appear tied to Medicaid. We are concerned that states will abuse the confusion of beneficiaries who may think the Medicaid and work search programs are somehow linked. Aside from this, however, we wholeheartedly support efforts by New Hampshire and other states to create independent and voluntary employment supports for lower income individuals, as accessible employment supports

[1] *See generally* Social Security Aact (SSA) § 1902.
[2] *Id.* §§ 1902(a)(10)(A), (B).
[3] *Camacho v. Texas Workforce Comm'n,* 408 F.3d 229, 235 (5th Cir. 2005), *aff'g*, 326 F. Supp. 2d 803 (W.D. Tex. 2004) (finding that Texas could not "add additional requirements for Medicaid eligibility"). *See generally Carleson v. Remillard,* 406 U.S. 598 (1972) (invalidating state law that denied AFDC benefits to children whose fathers were serving in the military where no such bar existed in federal law governing eligibility).

are services that our clients, particularly those with disabilities, have sought and been denied for decades.

New Hampshire's application attempts to connect a work program to health by arguing that:

> "It is in New Hampshire's *economic* and *financial* interest to facilitate sustained employment or a return to sustained employment for as many participants as possible. Gaining *financial* stability will enable some participants to mitigate negative environmental and *economic* factors that can contribute to poor health."[4]

The state is explicitly attempting to justify using Medicaid to advance economic interests (for the state and individuals), on the theory that these "contribute" to health. HHS cannot accept this argument for several reasons. The Social Security Act is clear that the purpose of Medicaid is to "to furnish … medical assistance on behalf of" eligible individuals, not advance financial interests.[5] Furthermore, we note that *National Federation of Independent Business v. Sebelius* found that even extending Medicaid to provide *health care* stretches the statutory intent; it would therefore be preposterous to extend Medicaid to provide economic development or work programs.[6] Finally, if HHS accepted New Hampshire's argument based on "contribution" to health, it would create an impossibly broad standard that could allow Medicaid eligibility conditioned upon education, traffic safety, criminal justice issues, etc.

C. Citizenship and Residency Verification

New Hampshire has proposed several waivers to implement draconian citizenship and state residency verification requirements, although there is no record of problems with the existing state data matching systems. The state proposes to require two forms of identification for citizenship and a state-issued photo identification card for state residency. By implication, qualified immigrants who are eligible for Medicaid could not enroll, because they couldn't prove they are citizens. It is unclear whether the state actually intends to bar otherwise eligible legal immigrants from the program but that would be the consequence of requiring documentation of *citizenship* from all applicants.

These extreme policies are inconsistent with numerous features of the law on verifying citizenship status, which states can satisfy using a pre- or post-CHIPRA (2009) methodology. The requirement to provide two forms of identification for citizenship violates the requirements set out in the pre-CHIPRA methodology which explicitly allows one document to satisfy the requirements in some circumstances.[7] The requirement is also incongruent with the data matching (non-documentation) approach created by CHIPRA, and contradicts the spirit of the CHIPRA option, which is to simplify and streamline administrative processes.[8] The requirement to provide a state-issued photo

[4] New Hampshire Health Protection Program application, page 9 (emphasis added).
[5] SSA § 1901.
[6] 132 S. Ct. 2566 (2012).
[7] SSA § 1903(x)(3)(A)(i).
[8] SSA § 1902(ee).

ID as proof of state residency is also unsupported in law because the state may not demand documentation from the applicant unless it has been unable to obtain (reasonably compatible) information through data-matching systems.[9]

Some of the waivers the state requests may involve provisions (namely §§ 1137 and 1903(x)) that lie outside of § 1902, and there is no authority in § 1115 to waive such provisions. (We cannot be sure of what the state intends to waive, because, as mentioned in Part A above, we have not been able to obtain a final waiver list.)

Such waivers also should not be approved because they do not represent innovations; they are in fact regressions to an administratively cumbersome past where documentation requirements interfered with efficient enrollment. The Affordable Care Act explicitly streamlined enrollment for MAGI populations to *avoid* such antiquated systems. They will certainly result in enrollment delays and failures for many individuals who are eligible to enroll. Such an approach will also do nothing to promote the objectives of Medicaid and will almost certainly fail to maintain budget neutrality since it will increase administrative costs. Congress has spoken clearly about what is needed to prove citizenship and state residency. The burden should be on New Hampshire to identify any evidence or facts supporting the need for an alternative to the Congressional standards. Since New Hampshire has not provided any such evidence, the requested waiver should not be approved.

D. Non-Emergent ER Use Copayments

New Hampshire has requested §1115 demonstration authority to charge heightened copays of $25 per visit for non-emergent use of the ER. Such copays are only permissible for individuals above 150% of FPL; individuals below 150% can only be charged nominal copayments.[10] Recent regulations provide states with generous flexibility to charge as much as $8 for non-emergent ER visits for populations below 150% FPL.[11] There is no authority to impose a $25 copay – over three times the legal limit. The law is clear; the policy, heavily studied. Furthermore, HHS cannot approve a waiver of cost-sharing unless the experiment complies with all the conditions in § 1916(f).

Section 1115 cannot be used to approve such a waiver for a number of reasons. First, the cost-sharing limits in § 1916 cannot be waived under § 1115. Section 1115 explicitly circumscribes HHS's waiver authority for Title XIX to requirements contained in § 1902.[12] Anything outside of § 1902 is not legally waivable through the §1115 demonstration process. Moreover, HHS may not approve a waiver of § 1916 cost sharing provisions under *any* waiver authority unless the demonstration first meets the tightly circumscribed requirements of § 1916(f). Any attempt by New Hampshire to implement heightened ER copayments without complying with § 1916(f) would be illegal.

[9] 42 C.F.R. § 435.952(c).
[10] SSA §§ 1916(a)(3), 1916(b)(3).
[11] 42 C.F.R. § 447.54.
[12] SSA § 1115(a)(1).

Among other requirements, the copay experiment would have to test a unique and previously untested use of copays where the benefits to beneficiaries are likely to match or outweigh the risks. Cost-sharing has already been shown to be a barrier to low-income populations accessing care, and multiple studies published in the last six years have all found that nonemegency ED copays in Medicaid and CHIP have had no effect on reducing ED use.[13] HHS itself, in a recently released bulletin on best practices to reduce unnecessary ED use, acknowledges that strategies like expanding access to primary care or providing health homes for frequent ED users may be effective, but suggests that increased copays for nonemergency use are problematic.[14] Tripling the copay, therefore, offers no positive experimental value to beneficiaries and would undermine the objective of the Medicaid Act to furnish medical assistance for enrollees. For additional information, *see* David Machledt and Jane Perkins, *Medicaid Cost-Sharing and Premiums* (March 2014), available at: http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing.

We note that the individuals subject to this charge may be extremely poor, and even an $8 charge would already be a tremendous burden. A higher copay would also nonsensically put a heavy onus on consumers – including those with injuries, pain, and disorientation – to self-assess the status of their own condition in real time. Finally, if HHS approved any heightened copayments then HHS would need to carefully monitor New Hampshire's compliance with statutory requirements that the facility cannot charge an ED copay until it has:

- screened the individual using a legitimate process to discern emergent from non-emergent conditions;
- provided notice that the care to be provided is non-emergent care subject to additional charges;
- identified an "actually available and accessible" alternative care option with lower or no cost sharing; and
- provided the enrollee with a referral.[15]

[13] General evidence suggests that increased copays may discourage unnecessary *and* necessary ED care, especially for low-income enrollees. *See* J. Frank Wharam et al., *Emergency Department Use and Subsequent Hospitalizations among Members of a High-Deductible Health Plan*, 297 JAMA 1093, 1098 (2007) and Joe V. Selby et al., *Effect of a Copayment on Use of the Emergency Department in a Health Maintenance Organization*, 334 New Eng. J. Med. 638 (1996). Evidence specific to Medicaid and CHIP has repeatedly found that copays have no discernible effect on ED utilization (emergency or nonemergency) for Medicaid enrollees. *See* Karoline Mortensen, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments*, 29 Health Aff. 1643 (2010); David J. Becker et al., *Co-payments and the Use of Emergency Department Services in the Children's Health Insurance Program*, 70 Med. Care Res. Rev. 514–529 (2013); Mona Siddiqui, Eric T. Roberts and Craig E. Pollack, *The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005*, 175 JAMA INTERNAL MED. 393 (2015).

[14] CMS, *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings* (Jan. 16, 2014), http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf; see *also* Wash. State Health Care Authority, *Emergency Department Utilization: Assumed Savings from Best Practices Implementation* (2013).

[15] SSA § 1916A(e)(1).

Conclusion

In summary, we have concerns with the legality of several components of New Hampshire's § 1115 demonstration application, as proposed. We fully support the use of § 1115 of the Social Security Act to implement true experiments. We strongly object, however, to any efforts to use § 1115 to skirt essential provisions that Congress has placed in the Social Security Act to protect Medicaid beneficiaries and ensure that the program operates in the best interests of the population groups described in the Act. We urge HHS to address our concerns prior to issuing any approval. If you have questions about these comments, please contact Leonardo Cuello (cuello@healthlaw.org). Thank you for consideration of our comments.

Sincerely,

Leonardo D. Cuello
Director, Health Policy